STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	05/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00105618, IN00107262, IN00107366, IN00107648. Complaint IN00105618 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282. Complaint IN00107262 - Substantiated. Federal/state deficiencies related to the allegations are cited at F203 and F250. Complaint IN00107366 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226 and F250. Complaint IN00107648 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F498. Survey dates: April 29, 30, May 1, 2, 3, and 4, 2012 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Survey team: Sandra Haws, RN - TC	F0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Vicki Manuwal, RN Marcia Mital, RN (4/30, 5/1, 5/2, 2012) Regina Sanders, RN (4/30, 5/1, 5/2, 2012) Census bed type: SNF/NF 108 Total: 108 Census payor type: Medicare 14 Medicaid 70 Other 24 Total: 108 Sample: 22 Supplemental sample: 9 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/11/12 by Suzanne Williams, RN		submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.	

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F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State			

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	long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on interviews and record review, the facility failed to ensure a resident's family was given ample notice to find alternative placement after being informed the resident needed to be discharged or provide the family with a Notice of Transfer or Discharge to inform them of their appeal rights for 1 of 5 residents reviewed for discharge in a sample of 22. (Resident # E) Findings include: Resident # E's closed record was reviewed on 5/2/12 at 1:40 p.m. The resident's record indicated diagnoses of, but not limited to; senile dementia, malaise and pyelonephritis. The record indicated the resident was admitted to the facility on 4/16/10. Review of Resident # E's Significant	F0203	1. Resident E was discharged from the facility prior to the survey. 2. All residents with discharge potential have the potential to be affected. A facility audit of discharge potential will be conducted, and a 30 day notice of discharge will be presented when warranted. 3. The Interdisciplinary Team was inserviced on the policy and procedure for transfer/discharge including documentation of actions taken toward discharge. Social Service Director/designee will audit all residents for changes in discharge potential through clinical meeting weekly for necessity of issuance of the required notice of discharge. The discharge notice will be issued as required. 4. SSD/designee will maintain the log of residents reviewed for necessity of issuance of notice of discharge. The log will be reviewed monthly X 6 months in the facility's	06/09/2012

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	change MDS (minimum data set) assessment dated 7/21/11, indicated her cognition was moderately impaired, she needed limited assistance with 1 staff for transfers, and supervision/oversight with ambulation. She required extensive assistance with dressing, and bathing. The MDS indicated she was frequently incontinent of her bowel and bladder function. The resident's record indicated a plan of care dated 7/21/11 indicating the resident was at risk for elopement and had a wanderguard in place. The interventions included; "Wanderguard in place at all times, check placement, encourage participation in areas frequented by staff, redirect as needed and to document any attempts to leave, notify M.D. (medical doctor)/ family." Elopement risk evaluations completed quarterly indicated an assessment completed on 1/1/11, documented "Resident is currently Hospice makes no attempts to wander or has made no attempts for elopement, continues to wear wanderguard." An elopement risk evaluation dated 12/16/11 indicated "Resident attempting to exit seek going to all the doors. Wanderguard on w/c (wheelchair) and		Performance Improvement Committee meeting to ensure 100% compliance with notice of discharge is issued as required.	

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	placed on 15 min (minute) checks." Nurses note dated 3/31/12 at 11:45 p.m. indicated "Res exit seeking 'looking for my car' res opened an exit door but did not make it outside before staff responded to alarms and redirected her. 15 minute checks initiated...." A Social Service note dated 4/2/12 with a notation of "late entry for 3/29/12" indicated "...Res (resident) had reported exit seeking 3/31/12 easily redirected. Safety measures in place. No further incidents. Res disoriented at times, staff redirect as needed...will occ (occasionally) attend group programming or meals or (out of room). Family provides support. Res is pleasant and cooperative during this visit...." A nurses' note on 4/5/12 at 1:00 p.m. indicated "...No attempts to elope made this shift. Pleasant/cooperative with staff." An elopement risk evaluation dated 4/7/12, indicated "Resident observed outside walking down sidewalk pushing w/c. Immediately brought back into facility and placed on 1:1 supervision." Interviews conducted through the facility's investigation indicated the staff interviewed had indicated the alarm was			

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	sounding for 1 to 2 minutes. The facility's investigation further indicated the resident was seen by other staff walking to the parking lot and was brought back into the facility. The resident's record indicated she was receiving 1:1 supervision after the elopement. Nurse note dated 4/8/12 timed 03:10 (3:10 a.m.) indicated "Res left building at start of shift. Found outside by this writer and CNA. Returned to facility without difficulties. DON (Director of Nursing) and ED (Executive Director) notified. 1 to 1 started. Wanderguard in place to (R) (right) ankle and functioning. 15 minute checks cont. Will cont to monitor." A Social Service note dated 4/11/12 (untimed) indicated "No attempts to elope noted/reported. Res expressing no exit seeking behavior statements. CP (care plan) in place. Safety measures continue." The note continued on the same day, untimed, "Contacted res RP (responsible party)/son at request of Administration to facilitate family mtg (meeting) to discuss res elopement risk and possible options to promote her safety and meet her needs. Mtg scheduled for 4/13/12 at 4 p.m...." Request was made to Social Service Director and the Director of Nursing on 5/3/12 at 12:00 p.m. for Social Service			

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	notes regarding the meeting that was held with the family on 4/13/12. No notes were provided. A piece of printer paper with a heading of "Nursing facilities South Bend" was reviewed, with a list of 12 area nursing homes listed. A notation at the bottom indicated "*Presented to family at meeting on 4/13/12." Nurses note dated 4/24/12 indicated "Discharged from facility, transport via (ambulance company name) Personal items with family. Inventory sheet signed. No further action required." During a phone interview with the resident's family on 5/3/12 at 10:15 a.m. she indicated the facility only gave them a week to get her out of the facility. She indicated afterwards she spoke with the Ombudsman and found out she wasn't supposed to be discharged like that. The family indicated they both had to take off work to find placement quickly. She indicated her husband who was the acting Power of Attorney had to call the area Ombudsman for help. She also indicated the facility only met with them once on 4/13/12 for only 20 to 30 minutes and indicated they left and didn't know what to do. The family indicated the facility never informed them there was a problem			

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	with the resident until that day (April 13th). The family stated they didn't feel they had a choice and didn't want to have to move her due to her age. The family indicated they were never given a Notice of Transfer or Discharge at any time. The family further indicated they were informed on April 13th they needed to find alternative placement right away so they started looking and found alternative placement that week. The resident was discharged 11 days later on the 24th of April 2012. The resident's record indicated a Notice of Transfer or Discharge form in the resident's closed record dated 4/24/12. The resident was discharged on 4/24/12. During an interview with the Director of Nursing regarding Resident # E or the family not receiving a 30 day Notice of Transfer or Discharge, 5/3/12 at 9:10 a.m., she indicated they didn't have to, because the family hadn't found placement yet and could have only issued one if the resident had a place to go. The Director of Nursing also indicated it was the facility who decided to discharge the resident as they felt they could not meet her needs. She indicated the family was in agreement and was looking for a place to put her.			

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	During a phone interview with the Ombudsman regarding the discharge of Resident # E, on 5/3/12 at 10:23 a.m., she indicated she spoke with the family after the April 13th meeting with the facility. The Ombudsman indicated she then met with the facility's Social Service Director regarding the concern the family had with the resident's discharge. The Ombudsman indicated she informed the Social Service Director that he needed to issue the family a 30 day Notice of Transfer or Discharge. The Ombudsman further indicated she was never sent a notice the resident had been transferred to another facility. On 5/4/12 at 10:20 a.m. interview with the family indicated they wanted to provide a copy of a letter the resident's son (POA) had sent to the corporate office regarding the rushed discharge without assistance from the facility. The letter was dated 4/14/12 and indicated "To Whom it may concern, I have been notified that I need to find another facility for my Mother (Resident # E) who resides at (facility name and address). On April 6, 2012 my Mother was found outside of their building in the evening hours by staff members that were coming into work. We were informed that when a staff member was going out of the building, my Mother followed them out as the door did not completely close. As I am			

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	concerned for her safety, I am concerned that I have to find another facility, as this one in (sic) not a locked unit. On my Mother's admission 2 years ago, I was not informed this was not a locked unit. She was admitted for Dementia at that time. I do not feel that my Mother is a threat nor should be subjected to a move that will confuse her even more. I had many questions in a family meeting that took place on 4/13/12 with an LPN unit manager and a social worker. We were informed that the administrator, who was not present (Administrator # 13) wants her moved. When I inquired to talk to (Administrator # 13), the nurse stated that 'I could but she will tell you that your Mother cannot stay here because we are not a locked unit.' I believe that this is more of a staffing issue and liability. I do not understand that as a patient, my Mother cannot be forced to stay in her room, however, I am concerned about the quality of care and her well being. I have also been informed that I have a week to make other arrangements and as my wife and I both work, this may take longer than a week...." The letter was signed by the POA. The resident's plan of care dated 4/12/12 reviewed on 5/3/12 at 1:00 p.m., indicated "D/C (discharge) plan uncertain/pending at this time- Res requires secured unit."			

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	Interventions listed indicated " Assist resident and family as needed during decision making, D/C planning process (SS) (Social Services), Provide education/training/recommendations prn (as needed), Facilitate mtg prior to discharge, Review available community resources with resident/family. Refer and or arrange for community resources as needed, provide education and support prn." This Federal tag relates to Complaint IN00107262. 3.1-12(a)(5)			

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F0223 SS=A	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse by facility staff for 1 of 7 residents reviewed for abuse in a sample of 22. Resident # F Findings include: The clinical record for Resident # F was reviewed on 5/2/12 at 4:40 P.M. The resident's diagnoses included, but were not limited to: hypothyroidism, hypertension, and congestive heart failure. Review of a "Resident Progress Notes" dated 1/11/12, indicated, "...Resident reported to me that someone was being rough c (with) her, rolling her around in her bed. She stated that this person was yelling at her for going to the bathroom in her brief. Son was called...." Review of a "Incident Report Form" dated	F0223	1. Resident F has been discharged from the facility. 2. All other residents with an allegation of abuse have the potential to be affected. Department Heads will conduct interviews with interviewable residents to determine outstanding issues. Administrator will act on these reports per policy. 3. All staff was inserviced on the policies and procedures for responding to an allegation of abuse. The Administrator will review the nature of all allegations to determine if the criteria have been met for abuse and to ensure timely execution of related policies and procedures. Department Heads will interview 5 residents per week to determine outstanding allegations of abuse. 4. The Administrator will audit all allegations. The audit will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance. The facility respectfully requests an IDR for this citation. The event cited was	06/09/2012

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	1/11/12, sent to the Indiana State Department of Health, indicated, "... [Resident # F] states she was moved roughly during the night by a woman with a deep, rough voice. Upon interview, [Resident # F] states that [CNA # 14] was rough with her while rolling her in the bed and that she scolded her for "making a mess." [CNA # 14] states she provided care to Resident # F gently, and denies scolding her for soiling herself. Staff, residents, and families of residents to whom [CNA # 14] provides care do not have issues with her care....[CNA # 14] suspended pending investigation. Investigation initiated. MD & family aware....[CNA # 14] re-educated. She will be reinstated to her position with Kindred and be monitored by nurse management for provision of care per policy. Social Services will continue to monitor [Resident # F's] psychosocial well-being...." Review of a facility "Alleged Abuse, Neglect and Exploitation Investigation Worksheet" dated 1/11/12, indicated, "...Physical Abuse...Verbal Abuse...Resident stated that someone during the night was being rough c her and rolling her around in her bed roughly. She stated that this person was yelling at her for 'making a mess' in her brief....CNA suspended pending		not substantiated as cited as per facility investigation of the event.	

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	investigation...." Review of a facility policy titled "Protection of Resident During An Investigation" revised 4/28/09, indicated, "...A staff member implicated in an abuse/neglect situation, regardless of discipline, will be: a. Immediately removed from any resident contact b. Interviewed and version of event documented c. Suspended pending investigation results..." This Federal tag relates to Complaint IN00107366. 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	05/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure staff responded	F0225	1. For Resident B, alleged perpetrator was suspended pending results of investigation,	06/09/2012

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	correctly to an allegation of abuse for 1 of 4 allegations of abuse reviewed related to not calling the Administrator, protecting the resident from further potential abuse, completing a thorough investigation, and reporting the allegation to the Indiana State Department Health, for 1 of 7 residents reviewed for abuse in a sample of 22. (Resident B) Findings include: 1. Resident B's record was reviewed on 4/30/12 at 1:10 p.m., Resident B's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and osteoporosis. A Quarterly MDS (minimum data set) assessment, dated 2/8/12, indicated the resident had moderate cognitive impairment and the resident required extensive assistance of two staff members for bed mobility and transfers. During an interview on 4/30/12 at 12:45 p.m., LPN #1 indicated yesterday afternoon (Sunday) she had received a phone call from the Weekend Manager, RN #2. She indicated RN #2 had tried to call the Director of Nurses (DoN), but was not able to reach her so RN #2 had called her. She indicated RN #2 had told her Resident B had reported a CNA had		Administrator was notified of incident, the investigation was completed, and the incident was reported to the Indiana State Department of Health during the survey.2. All other residents with an allegation of abuse have the potential to be affected. Department Heads will conduct interviews with interviewable residents to determine outstanding issues. Administrator will act on these reports per policy. 3. All staff was inserviced on the policies and procedures for responding to an allegation of abuse. The Administrator will review the nature of all allegations to determine if the criteria have been met for abuse and to ensure timely execution of related policies and procedures. Department Heads will interview 5 residents per week to determine outstanding allegations of abuse.4. The Administrator will audit all allegations. The audit will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	

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	yelled at her. She indicated there had been two CNAs in the room at the time. She indicated the Resident had stated the CNA had told the resident "Your yelling at me. I don't have to take this from you." She indicated the resident had said the CNA who had yelled at her was not the CNA taking care of her that day. She indicated she had told RN #2 to get statements from both CNAs. She indicated RN #2 had talked to both CNAs and CNA #3 was the CNA the resident had said yelled at her. She indicated she had told RN #2 not to let CNA #3 go into Resident B's room anymore and to have the CNAs work in pairs. She indicated she had talked to the resident when she came into work this morning (Monday) and the resident had said "more or less nothing was going on." She indicated she had not notified the Administrator. She indicated the CNA had not been sent home. She indicated the CNA had continued to work but did not take care of Resident B. During an interview on 4/30/12 at 1 p.m., the Administrator indicated she had not been informed of any allegations of abuse yesterday. During an interview on 4/30/12 at 1:02 p.m., LPN #1 indicated she had received the call from RN #2 at about 4 p.m.			

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	yesterday. During an interview on 4/30/12 at 1:04 p.m. the DoN indicated she was not aware of the allegation until a few minutes ago. She indicated it had not been reported to Indiana State Department of Health. During an interview on 4/30/12 at 1:04 p.m., the Administrator indicated the CNA should have been suspended until they investigated the allegation. During an interview on 4/30/12 at 1:30 p.m., RN #2 indicated Resident B had reported to him on 4/29/12 the aides got her up and put her in her chair and then one of the aides said "If you don't quit yelling I'm not going to help you." RN #2 indicated the resident was not able to tell him who the aide was. He indicated he went to find out who was working with the resident that day. He indicated the Resident had said it was not her aide but someone who had came in to help. He indicated he had talked to the resident's CNA (CNA #4) and she had told him after getting the resident into her chair the resident had began screaming at CNA #3 and then CNA #3 said she couldn't do this and had stepped out of the room. He indicated he had then went and talked to CNA #3. He indicated CNA #3 told him she had been helping with Resident B and			

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	then Resident B had began yelling so she had left the room. He indicated he had told CNA #3 not to take care of Resident B. He indicated he had tried to call the DoN but did not get an answer so he had called LPN #1. He indicated LPN #1 had told him to fill out a grievance and to get statements from the CNAs. He indicated he had protected the resident by not letting CNA go into Resident B's room. He indicated LPN #1 had not told him to suspend anyone just told him to get statements from the CNAs. During an interview on 4/30/12 at 1:35 p.m., Resident B indicated a CNA had yelled at her. She indicated two CNAs were getting her up and one was pulling one way and the other was pulling her the other way. She indicated the CNA had said "I'm not going to stand here and listen to you cry and yell and walked out of the room." She indicated she had reported it right away but she was not sure who she had reported it to. A "Complaints/Grievances" form, dated 4/29/12, signed by RN #2, indicated "...Issues...Pt (Patient) reported that one of the CNAs came into her room and told her she would not help her unless if she quits yelling, screaming, and crying and left the room. Upon investigation CNA assisted to pt reported she had asked			

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	another CNA to help c (with) care/transfer and pt started screaming at the CNA who reported to the CNA that she had to leave because pt was screaming at her." This Federal tag relates to Complaint IN00107366. 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their abuse prevention policy and procedure was implemented for 1 of 4 allegations of abuse reviewed, related to not calling the Administrator, protecting the resident from further potential abuse, completing a thorough investigation, and reporting the allegation to the Indiana State Department Health, for 1 of 7 residents reviewed for abuse in a sample of 22. (Resident B) Findings include: 1. Resident B's record was reviewed on 4/30/12 at 1:10 p.m., Resident B's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and osteoporosis. A Quarterly MDS (minimum data set) assessment, dated 2/8/12, indicated the resident had moderate cognitive impairment and the resident required extensive assistance of two staff members for bed mobility and transfers.	F0226	1. For Resident B, alleged perpetrator was suspended pending results of investigation, Administrator was notified of incident, the investigation was completed, and the incident was reported to the Indiana State Department of Health during the survey.2. All other residents with an allegation of abuse have the potential to be affected. Department Heads will conduct interviews with interviewable residents to determine outstanding issues. Administrator will act on these reports per policy. 3. All staff was inserviced on the policies and procedures for responding to an allegation of abuse. The Administrator will review the nature of all allegations to determine if the criteria have been met for abuse and to ensure timely execution of related policies and procedures. Department Heads will interview 5 residents per week to determine outstanding allegations of abuse.4. The Administrator will audit all allegations. The audit will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure	06/09/2012

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	During an interview on 4/30/12 at 12:45 p.m., LPN #1 indicated yesterday afternoon (Sunday) she had received a phone call from the Weekend Manager, RN #2. She indicated RN #2 had tried to call the Director of Nurses (DoN), but was not able to reach her so RN #2 had called her. She indicated RN #2 had told her Resident B had reported a CNA had yelled at her. She indicated there had been two CNAs in the room at the time. She indicated the Resident had stated the CNA had told the resident "Your yelling at me. I don't have to take this from you." She indicated the resident had said the CNA who had yelled at her was not the CNA taking care of her that day. She indicated she had told RN #2 to get statements from both CNAs. She indicated RN #2 had talked to both CNAs and CNA #3 was the CNA the resident had said yelled at her. She indicated she had told RN #2 not to let CNA #3 go into Resident B's room anymore and to have the CNAs work in pairs. She indicated she had talked to the resident when she came into work this morning (Monday) and the resident had said "more or less nothing was going on." She indicated she had not notified the Administrator. She indicated the CNA had not been sent home. She indicated the CNA had continued to work but did not take care of Resident B.		100% compliance.	

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	During an interview on 4/30/12 at 1 p.m., the Administrator indicated she had not been informed of any allegations of abuse yesterday. During an interview on 4/30/12 at 1:02 p.m., LPN #1 indicated she had received the call from RN #2 at about 4 p.m. yesterday. During an interview on 4/30/12 at 1:04 p.m. the DoN indicated she was not aware of the allegation until a few minutes ago. She indicated it had not been reported to Indiana State Department of Health. During an interview on 4/30/12 at 1:04 p.m., the Administrator indicated the CNA should have been suspended until they investigated the allegation. During an interview on 4/30/12 at 1:30 p.m., RN #2 indicated Resident B had reported to him on 4/29/12 the aides got her up and put her in her chair and then one of the aides said "If you don't quit yelling I'm not going to help you." RN #2 indicated the resident was not able to tell him who the aide was. He indicated he went to find out who was working with the resident that day. He indicated the Resident had said it was not her aide but someone who had came in to help. He			

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	indicated he had talked to the resident's CNA (CNA #4) and she had told him after getting the resident into her chair the resident had began screaming at CNA #3 and then CNA #3 said she couldn't do this and had stepped out of the room. He indicated he had then went and talked to CNA #3. He indicated CNA #3 told him she had been helping with Resident B and then Resident B had began yelling so she had left the room. He indicated he had told CNA #3 not to take care of Resident B. He indicated he had tried to call the DoN but did not get an answer so he had called LPN #1. He indicated LPN #1 had told him to fill out a grievance and to get statements from the CNAs. He indicated he had protected the resident by not letting CNA go into Resident B's room. He indicated LPN #1 had not told him to suspend anyone just told him to get statements from the CNAs. During an interview on 4/30/12 at 1:35 p.m., Resident B indicated a CNA had yelled at her. She indicated two CNAs were getting her up and one was pulling one way and the other was pulling her the other way. She indicated the CNA had said "I'm not going to stand here and listen to you cry and yell and walked out of the room." She indicated she had reported it right away but she was not sure who she had reported it to.			

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A "Complaints/Grievances" form, dated 4/29/12, signed by RN #2, indicated "...Issues...Pt (Patient) reported that one of the CNAs came into her room and told her she would not help her unless if she quits yelling, screaming, and crying and left the room. Upon investigation CNA assisted to pt reported she had asked another CNA to help c (with) care/transfer and pt started screaming at the CNA who reported to the CNA that she had to leave because pt was screaming at her."

A facility policy, titled "Abuse", dated 10/26/11, received from the DoN as current, indicated "...All alleged violations involving...abuse...are reported immediately to the administrator of the facility and to other officials in accordance with state law..."

A facility policy, titled "Protection of Resident During An Investigation", dated 04/28/09, received from the DoN as current, indicated "...Reasonable measures are taken to protect a resident during an investigation of abuse...A staff member(s) implicated in an abuse/neglect situation, regardless of discipline will be: a. immediately removed form any resident contact. b. Interviewed and version of event documented. c. Suspended

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	pending investigation results..." A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "...The investigation...Specify the type of allegation that is being reported...Document the details of the incident...Interview staff members, visitors and/or residents who may have knowledge of alleged incident....Staff that cared for the resident(s) at the time of alleged incident...Residents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard something...Visitors who might have witnessed the incident..." This Federal tag relates to Complaint IN00107366. 3.1-28(a)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record reviews and interviews, the facility failed to provide social services for the necessary assistance and guidance for a resident and family needing assistance with discharge from the facility due to elopement behaviors for 1 of 5 residents reviewed for discharge (Resident # E) and failing to provide the necessary follow-up to evaluate the psychosocial well being of a resident related to an abuse allegation, for 1 of 7 residents reviewed for abuse in a sample of 22. (Resident # F) Findings include: 1. Resident # E's closed record was reviewed on 5/2/12 at 1:40 p.m. The resident's record indicated diagnoses of, but not limited to; senile dementia, malaise and pyelonephritis. The record indicated the resident was admitted to the facility on 4/16/10. Review of Resident # E's Significant change MDS (minimum data set) assessment dated 7/21/11, indicated her cognition was moderately impaired, she	F0250	1. Residents E & F were discharged from the facility prior to the survey. 2. All other residents and families requiring medically-related social services have the potential to be affected. Social Service Director/designee will review all residents for the necessity of these services and establish a plan of care for provision of the services as required. 3. Social Service Department was inserviced on establishing a plan of care for provision of and implementation of required medically-related social services. Social Service Director will review all residents for appropriate assessment and documentation through clinical meeting weekly and at least quarterly through the care planning process to determine necessity of medically-related social services. 4. Social Service Director will review 10 charts monthly for assessment and documentation of medically-related social service intervention. These results will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	06/09/2012

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	needed limited assistance with 1 staff for transfers, and supervision/oversight with ambulation. She required extensive assistance with dressing, and bathing. The MDS indicated she was frequently incontinent of her bowel and bladder function. A Social Service note dated 4/2/12, with a notation of "late entry for 3/29/12," indicated "...Res (resident) had reported exit seeking 3/31/12 easily redirected. Safety measures in place. No further incidents. Res disoriented at times, staff redirect as needed...will occ (occasionally) attend group programming or meals oor (out of room). Family provides support. Res is pleasant and cooperative during this visit...." A nurse's note on 4/5/12 1:00 p.m., indicated "...No attempts to elope made this shift. Pleasant/cooperative with staff." An elopement risk evaluation dated 4/7/12, indicated "Resident observed outside walking down sidewalk pushing w/c. Immediately brought back into facility and placed on 1:1 supervision." Interviews by staff, documented with the facility's investigation, all indicated the alarm was sounding for 1 to 2 minutes. The interviews indicated she was seen by other staff walking to the parking lot and			

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	155219	A. BUILDING 00 B. WING	05/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was brought back into the facility. The resident's record indicated she was receiving 1:1 supervision. A nurse note dated 4/8/12 timed 03:10 (3:10 a.m.), indicated "Res left building at start of shift. Found outside by this writer and CNA. Returned to facility without difficulties. DON (Director of Nursing) and ED (Executive Director) notified. 1 to 1 started. Wanderguard in place to (R) (right) ankle and functioning. 15 minute checks cont. Will cont to monitor." A Social Service note dated 4/11/12 (untimed), indicated "No attempts to elope noted/reported. Res expressing no exit seeking behavior statements. CP (care plan) in place. Safety measures continue." The note continued on the same day, untimed, "Contacted res RP (responsible party)/ son at request of Administration to facilitate family mtg (meeting) to discuss res elopement risk and possible options to promote her safety and meet her needs. Mtg scheduled for 4/13/12 at 4 p.m...." During a phone interview with the Ombudsman regarding the discharge of Resident # E, on 5/3/12 at 10:23 a.m., she indicated she had spoke to the family and then met with the facility's Social Service Director regarding the resident's			

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	discharge. The Ombudsman indicated she informed Social Service Director that he needed to issue the family a 30 day Notice of Transfer or Discharge. The Ombudsman further indicated she was never sent a notice the resident had been transferred to another facility. During an interview with the Social Service Director on 5/3/12 at 11:45 a.m. regarding Resident # E's discharge, he indicated he gave the family a list of other facilities for them to look into on April 13th when he met with the family to discuss the resident's discharge. The Social Service Director indicated he recalled meeting with the Ombudsman and the information given to him about the need to issue the 30 day notice to the family, but he felt it wasn't necessary. Request was made to the Social Service Director and the Director of Nursing on 5/3/12 at 12:00 p.m. for Social Service notes regarding the meeting that was held with the family on 4/13/12, no notes were provided. A piece of printer paper with a heading of "Nursing facilities South Bend" was reviewed, with a list of 12 area nursing homes listed. A notation at the bottom indicated "*Presented to family at meeting on 4/13/12."			

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	Nurses note dated 4/24/12, indicated "Discharged from facility, transport via (ambulance company name) Personal items with family. Inventory sheet signed. No further action required." During a phone interview with the resident's family on 5/3/12 at 10:15 a.m. she indicated the facility only gave them a week to get her out of the facility. She indicated afterwards she spoke with the Ombudsman and found out she wasn't supposed to be discharged like that. The family indicated they both had to take off work to find placement quickly. She indicated her husband who was the acting Power of Attorney had to call the area Ombudsman for help. She also indicated the facility only met with them once on 4/13/12 for only 20 to 30 minutes and she indicated they left and didn't know what to do. The family indicated the facility never informed them there was a problem with the resident until that day. The family stated they didn't feel they had a choice and didn't want to have to move her due to her age. The family indicated they were never given a Notice of Transfer or Discharge at any time. The resident's record indicated a Notice of Transfer or Discharge form in the resident's closed record dated 4/24/12.			

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	The resident was discharged on 4/24/12. On 5/4/12 at 10:20 a.m., interview with the family indicated they wanted to provide a copy of a letter the resident's son (POA) had sent to the corporate office regarding the rushed discharge without assistance from the facility. The letter was dated 4/14/12 and indicated "To Whom it may concern, I have been notified that I need to find another facility for my Mother (Resident # E) who resides at (facility name and address). On April 6, 2012 my Mother was found outside of their building in the evening hours by staff members that were coming into work. We were informed that when a staff member was going out of the building, my Mother followed them out as the door did not completely close. As I am concerned for her safety, I am concerned that I have to find another facility, as this one in (sic) not a locked unit. On my Mother's admission 2 years ago, I was not informed this was not a locked unit. She was admitted for Dementia at that time. I do not feel that my Mother is a threat nor should be subjected to a move that will confuse her even more. I had many questions in a family meeting that took place on 4/13/12 with an LPN unit manager and a social worker. We were informed that the administrator, who was not present (Administrator # 13) wants			

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	her moved. When I inquired to talk to (Administrator # 13), the nurse stated that 'I could but she will tell you that your Mother cannot stay here because we are not a locked unit.' I believe that this is more of a staffing issue and liability. I do not understand that as a patient, my Mother cannot be forced to stay in her room, however, I am concerned about the quality of care and her well being. I have also been informed that I have a week to make other arrangements and as my wife and I both work, this may take longer than a week...." The letter was signed by the POA. The resident's plan of care dated 4/12/12, reviewed on 5/3/12 at 1:00 p.m., indicated "D/C (discharge) plan uncertain/pending at this time- Res requires secured unit." Interventions listed indicated " Assist resident and family as needed during decision making, D/C planning process (SS) (Social Services), Provide education/training/recommendations prn (as needed), Facilitate mtg prior to discharge, Review available community resources with resident/family. Refer and or arrange for community resources as needed, provide education and support prn." 2. The clinical record for Resident # F was reviewed on 5/2/12 at 4:40 P.M. The			

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	resident's diagnoses included, but were not limited to: hypothyroidism, hypertension, and congestive heart failure. Review of a "Resident Progress Notes" dated 1/11/12, indicated, "...Resident reported to me that someone was being rough c (with) her, rolling her around in her bed. She stated that this person was yelling at her for going to the bathroom in her brief. Son was called..." Review of a "Incident Report Form" dated 1/11/12, sent to the Indiana State Department of Health, indicated, "... [Resident # F] states she was moved roughly during the night by a woman with a deep, rough voice. Upon interview, [Resident # F] states that [CNA # 14] was rough with her while rolling her in the bed and that she scolded her for 'making a mess.' [CNA # 14] states she provided care to [Resident # F] gently, and denies scolding her for soiling herself. Staff, residents, and families of residents to whom [CNA # 14] provides care do not have issues with her care....[CNA # 14] suspended pending investigation. Investigation initiated. MD & family aware....[CNA # 14] re-educated. She will be reinstated to her position with Kindred and be monitored by nurse management for provision of care per policy. Social Services will continue to			

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	monitor [Resident # F's] psychosocial well-being...." Review of a facility "Alleged Abuse, Neglect and Exploitation Investigation Worksheet" dated 1/11/12, indicated, "...Physical Abuse...Verbal Abuse...Resident stated that someone during the night was being rough c her and rolling her around in her bed roughly. She stated that this person was yelling at her for 'making a mess' in her brief....CNA suspended pending investigation..." During interview with the Social Services Director on 5/3/12 at 2:30 P.M., he indicated the nursing staff made him aware of the incident the following day. He further indicated the son of Resident # F mentioned the incident to him the following week. He further indicated he was unsure if anyone told him about the resolution of the incident. He indicated he remembers the family coming into the facility a couple months ago to talk with the corporate nurse and he thought she took care of the matter. He further indicated he may have documented the incident and that he would check. The resident's record lacked documentation from Social Service regarding the incident. Request was made to the Social Service director at this time for any Social			

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	Service documentation regarding the incident. As of 5/4/12 at 1:00 P.M., no documentation has been provided from the Social Services Director. Review of the facility's policy for Social Services undated on 5/4/12 at 1:00 p.m. indicated "...Clinical Functions: Encourages involvement in family council and assists family council with meeting arrangements. Provides direct psychosocial intervention to residents and resident's families/significant others. Assists resident's families/significant others in coping with skilled nursing placement, physical illness and disabilities of the resident, and the grieving process...Documents observations and events in the resident's medical record as needed: assesses and documents psychosocial impact of life events, health concerns and condition change...." This Federal tag relates to Complaints IN00107262 and IN00107366. 3.1-34(a)			

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F0280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure residents were given the opportunity to participate in their plan of care, related to residents and a family members not being invited to participate in care planning meetings, for 2 of 3 residents identified by staff as alert and oriented, interviewed in a total sample of 22 (Residents #38 and #B) and 8 of 9 residents/family members, identified by staff as alert and oriented, interviewed in a supplemental sample of 9. (Residents #14, #22, #39, #50, #88, #91, #94, and #108). Findings include:	F0280	1. Residents B, 14, 22, 39, 50, 88, 91, and 108 have been informed of the notification process for residents and families to attend care planning meetings. Residents 38 and 94 have been discharged from the facility. 2. All other residents have the potential to be affected. Interdisciplinary team has notified all residents of the process for invitation to scheduled care planning meetings. 3. The interdisciplinary team has been inserviced on the resident and family notification process and documentation requirements of that notification for scheduled care planning meetings. MDS	06/09/2012

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	1. Resident #B was interviewed on 04/30/12 at 1:35 p.m. The resident indicated she had not been invited and had not participated in meetings where the staff planner her activities and daily medical and nursing care (care plan). Resident #B's record was reviewed on 05/01/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and vascular dementia. A Quarterly Minimum Data Set (MDS) Assessment, dated 02/09/12, indicated the resident had a moderate cognition impairment. A, "Care Plan Conference Summary", dated 02/23/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 02/23/12, to indicate the resident had been invited to the Care Plan Conference. 2. Resident #38 was interviewed on 05/01/12 at 8:55 a.m. The resident indicated she had not been invited and had not participated in Care Plan Conferences.		Coordinator/designee will notify all residents and families of scheduled care planning meetings, so they may participate as desired. 4. MDS Coordinator/designee will audit all resident and family notifications of scheduled care planning meetings monthly. These audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	

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Resident #38's record was reviewed on 05/01/12 at 2:50 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and vascular dementia.

A Significant Change MDS Assessment, dated 02/14/12, indicated the resident's cognition status was intact.

A, "Care Plan Conference Summary", dated 03/20/12, lacked documentation the Resident and/or Family attended the Care Plan Conference.

There was a lack of documentation in the resident's Progress Notes, dated 03/20/12, to indicate the resident had been invited to the Care Plan Conference.

3. Resident #39 was interviewed on 04/30/12 at 10:55 a.m. The resident indicated she had not been invited and had not participated in Care Plan Conferences.

Resident #39's record was reviewed on 05/01/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.

A Quarterly MDS Assessment, dated 02/06/12, indicated the resident's

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	cognition was moderately impaired. A, "Care Plan Conference Summary", dated 02/23/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 02/23/12, to indicate the resident had been invited to the Care Plan Conference. 4. Resident #50 was interviewed on 05/01/12 at 12 p.m. The resident indicated she had not been invited and had not participated in Care Plan Conferences. The resident's record was reviewed on 05/01/12 at 3 p.m., The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. A Quarterly MDS Assessment, dated 02/13/12, indicated the resident's cognition was intact. A, "Care Plan Conference Summary", dated 02/24/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 02/24/12,			

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	to indicate the resident had been invited to the Care Plan Conference. 5. Resident #88's spouse was interviewed on 04/30/12 at 11:45 a.m. The resident's spouse indicated she had not been invited and had not participated in Care Plan Conferences. A, "Care Plan Conference Summary", dated 02/22/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. 6. During a group interview on 05/01/12 at 1:45 p.m., Residents #14, #22, #91, #94, and #108 indicated they had not been invited and had not participated in Care Plan Conferences. A) Resident #91's record was reviewed on 05/01/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, Hypertension and congestive heart failure. A Quarterly MDS Assessment, dated 04/10/12, indicated the resident's cognition was intact. A, "Care Plan Conference Summary", dated 04/19/12, lacked documentation the Resident and/or Family attended the Care Plan Conference.			

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There was a lack of documentation in the resident's Progress Notes, dated 04/19/12, to indicate the resident had been invited to the Care Plan Conference.

B) Resident #108's record was reviewed on 05/01/12 at 3:35 P.M. The resident's diagnoses included, but were not limited to, late effect hemiplegia and constipation.

A Quarterly MDS Assessment, dated 01/01/12, indicated the resident's cognition was intact.

A, "Care Plan Conference Summary", dated 02/09/12, lacked documentation the Resident and/or Family attended the Care Plan Conference.

There was a lack of documentation in the resident's Progress Notes, dated 02/09/12, to indicate the resident had been invited to the Care Plan Conference.

C) Resident #14's record was reviewed on 05/01/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, hypertension and spinal stenosis.

A Significant Change MDS Assessment, dated 03/05/12, indicated the resident's cognition was intact.

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	A, "Care Plan Conference Summary", dated 03/06/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 03/06/12, to indicate the resident had been invited to the Care Plan Conference. D) Resident #22's record was reviewed on 05/01/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. A Quarterly MDS Assessment, dated 04/06/12, indicated the resident's cognition was intact. A, "Care Plan Conference Summary", dated 04/12/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 04/12/12, to indicate the resident had been invited to the Care Plan Conference. E) Resident # 94's record was reviewed on 05/01/12 at 3:45 p.m. The resident's diagnoses included, but were not limited to, hypertension and prostate cancer.			

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	155219	A. BUILDING 00 B. WING	05/04/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An Admission MDS Assessment, dated 02/01/12, indicated the resident's cognition was moderately impaired. A, "Care Plan Conference Summary", dated 03/29/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 03/29/12, to indicate the resident had been invited to the Care Plan Conference. During an interview on 05/01/12 at 11:30 a.m., MDS nurse #5 indicated the Receptionist sends invitations to the resident's family prior to the Care Plan Conference meetings. She indicated they do not keep copies of the letters and do not document the invitation in the chart. She indicated the residents' families are invited, not the residents. She indicated there is no documentation the residents have been invited to the Care Plan Conference. 3.1-35(d)(2)			

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	155219	A. BUILDING 00 B. WING	05/04/2012

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure medication orders were transcribed correctly to ensure residents received their medications as ordered by the physician. This deficient practice affected 4 of 22 residents reviewed for medication orders in a sample of 22. Resident # C, # H, # I, # J Findings include: 1. The clinical record for Resident # I was reviewed on 5/1/12 at 10:00 A.M. The resident's diagnoses included, but were not limited to: diabetes mellitus, hypertension, and hyperlipidemia. The clinical record indicated Resident # I was admitted to the facility on 4/6/12. Review of the (Name) Hospital "Patient Discharge Information" dated 4/6/12, indicated, "...Nateglinide (diabetes medication) 60 mg (milligrams) oral tablet...before meals..."	F0282	1. For Residents H and I, MD has clarified the order and corrections have been made to the clinical record as ordered. Residents C and J have been discharged from the facility. 2. All other residents have the potential to be affected. Pharmacy has audited all residents clinical records for transcription errors that may have occurred in the last 2 months with corrections made by the Unit Managers per Kindred policy and procedure. 3. Licensed nurses have been inserviced on policies and procedures related to transcription of physician's orders. All transcription of physician's orders will be verified by a second nurse to ensure accuracy. 4. Unit Managers will audit all transcription of physician's orders for accuracy. These audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	06/09/2012

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	Review of the facility "Admission Orders Record Continuation" dated 4/6/12, indicated, "...Nateglinide 60 mg p.o. (orally) before bed...2100 (9:00 P.M.)..." Review of the "Medication Record" undated, indicated Resident # I received the scheduled Nateglinide 60 mg each day at 9:00 P.M. from 4/7/12 thru 4/30/12. Review of a "Physician's Telephone Orders" dated 4/11/12, indicated, "...Starlix (Nateglinide) 60 (mg) c (with) meals, breakfast & dinner..." Review of the "Medication Record" undated, indicated Resident # I received the scheduled Nateglinide 60 mg each day at 8:00 A.M. and 5:00 P.M. from 4/15/12 thru 4/30/12. During interview with the DON on 5/3/12 at 2:20 P.M., she identified the above undated medication records as April 2012. Review of the "Diabetic Monitoring Flow Sheet" indicated Resident I's blood sugar ranged from 81 to 125 from 4/7/12 thru 4/30/12. Review of the May 2012, "Medication Record" lacked documentation of the order for Nateglinide 60 mg with meals, breakfast & dinner.			

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During interview with LPN # 11 on 5/1/12 at 12:00 P.M., she indicated Resident # I did not receive the scheduled morning dose of Nateglinide on 5/1/12 because it had not been transcribed on the MAR (medication administration record).

During interview with LPN # 10 on 5/1/12 at 12:05 P.M., she indicated two nurses are to verify the transcribed orders for accuracy. She further indicated she made the error because she was busy with numerous admissions that day.

Review of a Care Plan titled "...Unstable blood sugars R/T (related to) Dx. (diagnoses) of diabetes" dated 4/12/12, indicated, "...Administer medications as ordered...."

2. The clinical record for Resident # H was reviewed on 5/1/12 at 3:30 P.M. The resident's diagnoses included, but were not limited to: hypothyroidism, hyperlipidemia, and acute renal failure.

The clinical record indicated Resident # H was originally admitted 12/11/08 and readmitted 4/27/12.

Review of the (Name) Hospital "Patient Discharge Information" dated 4/27/12, indicated, "...levothyroxine (Synthroid)

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	(thyroid medication) 75 mcg (micrograms), oral, Mon (Monday) - Fri (Friday)...levothyroxine (Synthroid) 50 mcg, oral, on Sat (Saturday) and Sun (Sunday)..." Review of the facility "Admission Orders Record" dated 4/26/12, indicated, "...Synthroid 50 mcg p.o. (orally) on Sat & Sun..." The Admission Orders transcribed by the nurse lacked documentation of the ordered Synthroid 75 mcg for Monday through Friday. Review of the 4/26/12 thru 4/30/12 MAR and May 2012 MAR lacked documentation of the ordered Synthroid 75 mcg. During interview with LPN # 10 on 5/1/12 at 4:00 P.M., she indicated she was the nurse who failed to properly transcribe the medication orders. She further indicated the orders are to be double checked and that Resident # H's orders were doubled checked for accuracy as indicated by two nurses signatures on the admission orders. She further acknowledged Resident # H failed to receive the ordered Synthroid 75 mcg for 4 days. 3. The clinical record for Resident # C was reviewed on 5/2/12 at 2:00 P.M. The			

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	resident's diagnoses included, but were not limited to: depression, osteoporosis, and chronic back pain. The clinical record indicated Resident # C was admitted 1/5/12. Review of the (Name) Hospital "Patient Discharge Information" dated 1/5/12, indicated, "...aripiprazole (Abilify 20 mg...) (anti depressive medication)...1 tab, oral, once a day (at bedtime)..." Review of the facility "Admission Orders Record" dated 1/5/12, indicated a nurse transcribed the medication to be given "...Abilify 20 mg PO (orally) Q (every) day, 0730 (7:30 A.M.)..." instead to be given at bedtime as ordered by the physician. Review of the January 2012, MAR indicated Resident # C received the scheduled Abilify at 7:30 A.M. instead of the order to give at bedtime, January 6th through the 23rd of 2012. During interview with the DON on 5/2/12 at 3:00 P.M., she indicated the resident received the Abilify at 7:30 A.M. due to a transcription error. 4. The clinical record for Resident # J was reviewed on 5/2/12 at 10:55 A.M. The resident's diagnoses included, but			

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	were not limited to: gastroesophageal reflux disease, hypertension, and hypothyroidism. The clinical record indicated Resident # J was admitted to the facility on 4/20/12. Review of the (Name) Hospital "Patient Discharge Information" dated 4/20/12, indicated, "...pantoprazole (Protonix (reflux medication) 40 mg (milligrams) oral enteric coated tablet), oral, 2 times a day..." Review of the facility "Admission Orders Record Continuation" dated 4/20/12, indicated, "...Protonix 40 mg PO (orally) Q day (every day)...0730..." Review of the "Medication Record" dated 4/20/12 thru 4/30/12, indicated Resident # J received the scheduled Protonix 40 mg each day at 7:30 A.M. from 4/20/12 thru 4/30/12. During interview on 5/2/12 at 2:26 P.M., LPN # 10 indicated Resident # J did not receive the Protonix as ordered by the physician. Review of a facility policy titled "Readmission, Hand Written Orders, Written Transfer Orders or Faxed Orders" revised 10/31/09, indicated, "...Physician			

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	orders should be rewritten upon readmission to prevent missing an order, incorrectly continuing an order of to prevent transcription errors..." This Federal tag relates to Complaint IN00105618. 3.1-35(g)(2)			

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F0322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observations, interviews and record review, the facility failed to ensure a resident with a history of aspiration pneumonia and with a feeding tube, had her upper body elevated while her gastric feeding pump was running, for 1 of 3 residents reviewed receiving gastric tube feedings in a sample of 22. (Resident # 30) Findings include: During a tour of the unit on 4/30/12 at 11:10 a.m., an observation was made of Resident # 30 in a low bed. The head of the bed was observed elevated, but the resident's body had slid down in the bed, placing her chest area in a flat position. An observation was made of a feeding pump hooked up to the resident and the pump running at 50 cc an hour. LPN # 1 was summoned to observe the resident at this time. LPN # 1 took the bed controls and elevated the bed until the resident's	F0322	1. For Resident 30, the positioning of the Resident was corrected during the survey. 2. All residents with gastrostomy tubes have the potential to be affected. All residents with gastrostomy tubes have been reviewed by therapy for bed positioning requirements and plans of care for these residents have been updated to reflect the requirements. 3. All nursing staff have been inserviced on the positioning requirements for residents with gastrostomy tube feedings. Department heads will perform randomly timed audits 5 per week on all shifts to ensure compliance with positioning requirements. 4. DNS will track and trend audit results. Results of these audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	06/09/2012

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	upper body was in the correct position to prevent aspiration. Resident # 30's record was reviewed on 4/30/12 at 12:00 p.m. The resident's record indicated diagnoses of, but not limited to; dysphagia, malaise, fatigue and history of falls. The resident's quarterly MDS (Minimum Data Set) assessment dated 4/13/12, indicated her cognition was moderately impaired. She needed extensive assistance with 2 staff for transfers and total assistance with 1 staff for dressing and bathing. A report titled "History and Physical Exam" dated 11/15/11 indicated "(Resident # 30) was recently seen actually 7 months ago and has been doing well since she got her last PEG (Percutaneous Endoscopic Gastrostomy) tube in, comes in with what appears to be aspiration...Right upper lobe infiltrate consistent with pneumonia and she has been on Xosyn and vancomycin (antibiotics), but is afebrile almost immediately consistent with probable aspiration as is her chronic track record...Diagnostic Impression: Aspiration pneumonitis...." A physician's order dated 1/18/12 to			

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	current, indicated " Head of bed elevated 30 degrees at all times while feeding is running and for 1 hour after completion...." The resident's plan of care dated 1/27/12 indicated " (Resident # 30) has the potential for swallowing difficulty and alteration in nutrition status r/t (related to) dysphagia, parkinsons, dementia, hx (history of) weight loss, hx of aspiration. Resident is NPO (nothing by mouth). Interventions indicated "HOB (head of bed) 30 degrees as ordered, monitor for s/s (signs and symptoms) aspiration...." The facility's policy and procedure titled "Enteral Feeding: Pump Method (Open or Closed System) dated 2/24/12 was reviewed on 5/1/12 at 2:00 p.m. The policy indicated " ...9. Elevate the head of the bed to 30 - 45 degree angle during feeding and for at least one-hour after feeding is stopped...." 3.1-44(a)(2)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a CNA followed proper protocol while transferring a resident with a Hoyer lift which resulted in injury and transportation to the Emergency Department for treatment of a fracture of her lower leg, for 1 of 2 residents reviewed for fractures in a sample of 22. Resident # D Findings include: The clinical record for Resident # D was reviewed on 5/3/12 at 10:30 A.M. This resident's diagnoses included, but were not limited to: distal tibia and fibula fracture, dementia, and aphasia. Review of a SBAR (Situation-Background-Assessment-Recommendation) Physician...Communication and Progress Note dated 9/20/11, indicated, "...swelling noted to R (right) shin & leg/foot turned out...send to...ER for xray...CNA was getting ready to give	F0323	1. Resident D was discharged from the facility prior to the survey. CNA # 12 was terminated from employment with the facility prior to the survey. Certified Nursing Assistant competencies for mechanical lift transfers were performed at the time of discovery of the improper transfer. 2. All residents using hoyer lifts have the potential to be affected. 3. Certified Nursing Assistants have been inserviced on use of mechanical lifts per Kindred policy and procedure and have performed return demonstration. Certified Nursing Assistants will use 2 trained staff for all mechanical lift transfers. Unit Managers will perform 5 random of observations per week of mechanical lift transfers on all shifts. 4. DNS will track and trend audit results. Results of these audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance. The facility respectfully requests an IDR for the severity of this citation. The event cited did not lead to the injury as cited as per facility investigation of the event.	06/09/2012

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	resident a shower when she noticed that her R shin was swollen. I assessed shin & found swelling noted to area. No trauma noted. Skin of normal color, no redness, warmth noted. R leg laying on bed c (with) foot turned out...." Review of a "Facility Incident Reporting Form" dated 9/20/11, indicated, "... (Resident # D) was observed by staff to be laying in bed. Her right lower leg appeared deformed....Interviews reveal (Resident # D) had been laid down for bed per Hoyer lift 20-30 minutes prior to discovery. CNA caring for (Resident # D) states she was unaware of injury. (Resident # D's) care plan listed Hoyer lift for transfers. No other staff observed anyone else in (Resident # D's) room in the interim between transfer to bed and discovery. Re-enactment of the transfer revealed that 1 CNA performed the transfer. (Resident # D) returned from ER with splinted right lower leg...." Review of a Radiology Report dated 9/20/11, indicated, "...There is an acute oblique fracture through the distal tibial shaft...Minimally anterolaterally displaced spiral fracture of the distal fibular metadiaphysis..." Review of an undated internal facility reenactment with CNA # 12, indicated,			

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	"...I did not have assistance with the transfer...." Review of a "Performance Improvement Form" dated 9/23/11, indicated, "...(CNA # 12)...Failure to follow procedure for Hoyer transfers: transfer of residents on 9/19/11 without assistance. This failure may have lead to injury of (Resident # D): fracture to tibia and fibula...." Review of Resident #D's care plan titled "...Assist with all ADL's (activities of daily living)"..." dated 8/30/11, indicated, "...Hoyer lift for all transfers...." Resident # D's Significant change MDS (Minimum Data Set) assessment dated 8/30/11 indicated her cognition was severely impaired. She needed total assistance with 2 staff assistance with transfers and bathing. The MDS indicated she required a mechanical lift with 2 staff assistance for transfers. The MDS indicated the resident did not have a history of falls. Review of a facility policy titled "Mechanical Lift (Sling Lift)" revised 3/6/12, indicated, "...Obtain assistance from another staff member for transfer as necessary. Two people are required when using the Mechanical Lift..."			

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	Review of a facility policy titled "Accidents and Supervision to Prevent Accidents" revised 4/28/11, indicated, "...Center provides appropriate assistive devices to reduce the risk and/or prevent accidents. Ways to reduce risk and/or prevent risk are: Education of the staff in using assistive devices properly...Patient who becomes frightened during transfer in a mechanical lift may exhibit resistance movements that result in avoidable accidents...." This Federal tag relates to Complaint IN00107648. 3.1-45(a)(2)			

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F0368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview and record review, the facility failed to ensure residents were offered snacks at bedtime daily for 3 of 3 residents, identified by staff as alert and oriented, interviewed in a total sample of 22 (Residents #38, #71, and #B) and 7 of 8 residents, identified by staff as alert and oriented, interviewed in a supplemental sample of 9. (Residents #14, #22, #37, #39, #50, #91, and #94). This had the potential to affect 105 residents with oral diet orders, who reside in the healthcare facility. Findings include:	F0368	1. For Residents B, 14, 22, 37, 39, 50, and 91, education was provided related to facility procedure for offering of HS snacks. Residents 38, 71, and 94 have been discharged from the facility. 2. All residents who receive an HS snack have the potential to be affected. Interdisciplinary team has interviewed all residents to ensure HS snacks are being offered, with teaching provided on the procedure for those who are not aware.3. Licensed Nurses have been inserviced on the policy and procedure for offering HS snacks. Licensed nurses will offer an HS snack during HS med pass daily. Department Heads will	06/03/2012

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	155219	A. BUILDING 00 B. WING	05/04/2012

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	1. Resident #B was interviewed on 04/30/12 at 1:35 p.m. The resident indicated she does not get offered a bedtime snack. Resident #B's record was reviewed on 05/01/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and vascular dementia. A Quarterly Minimum Data Set (MDS) Assessment, dated 02/09/12, indicated the resident had a moderate cognition impairment. 2. Resident #38 was interviewed on 05/01/12 at 8:55 a.m. The resident indicated she does not get offered a bedtime snack. She indicated if she asks for one, she will get a snack. Resident #38's record was reviewed on 05/01/12 at 2:50 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and vascular dementia. A Significant Change MDS Assessment, dated 02/14/12, indicated the resident's cognition status was intact. 3. Resident #39 was interviewed on 04/30/12 at 10:55 a.m. The resident		interview 5 residents weekly to determine if they are being offered HS snacks. 4. DNS will track and trend the interview results. These results will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	

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	indicated she does not get offered a bedtime snack. She indicated if you ask for a snack, they will bring her fruit. Resident #39's record was reviewed on 05/01/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A Quarterly MDS Assessment, dated 02/06/12, indicated the resident's cognition was moderately impaired. 4. Resident #50 was interviewed on 05/01/12 at 12 p.m. The resident indicated she does not get offered a bedtime snack. she indicated if she wants a snack, she has to ask for it. The resident's record was reviewed on 05/01/12 at 3 p.m., The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. A Quarterly MDS Assessment, dated 02/13/12, indicated the resident's cognition was intact. 5. Resident #37 was interviewed on 05/01/12 at 9:40 a.m. The resident's diagnoses included, but were not limited to, bladder cancer and hypothyroidism. An Admission MDS Assessment, dated			

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	04/23/12, indicated the resident's cognition was intact. 6. During a group interview on 05/01/12 at 1:45 p.m., Residents #14, #22, #71 #91, and #94 indicated they do not get offered a snack at bedtime. A) Resident #91's record was reviewed on 05/01/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, Hypertension and congestive heart failure. A Quarterly MDS Assessment, dated 04/10/12, indicated the resident's cognition was intact. B) Resident 71's record was reviewed on 05/01/12 at 3:35 P.M. The resident's diagnoses included, but were not limited to, acute smoke inhalation and respiratory failure. The resident was admitted into the facility on 04/20/12. The Admission/5-day MDS Assessment, date 04/26/12, indicated the resident's cognition was intact. C) Resident #14's record was reviewed on 05/01/12 at 2:55 p.m. The resident's diagnoses included, but were not limited to, hypertension and spinal stenosis.			

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	A Significant Change MDS Assessment, dated 03/05/12, indicated the resident's cognition was intact. D) Resident #22's record was reviewed on 05/01/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus. A Quarterly MDS Assessment, dated 04/06/12, indicated the resident's cognition was intact. E) Resident # 94's record was reviewed on 05/01/12 at 3:45 p.m. The resident's diagnoses included, but were not limited to, hypertension and prostate cancer. An Admission MDS Assessment, dated 02/01/12, indicated the resident's cognition was moderately impaired. During an interview on 05/01/12 at 11:20 a.m., the Director of Nursing indicated the staff are supposed to offer the residents a bedtime snack. During an interview on 05/01/12 at 4:40 p.m. CNA #6 indicated she gave the residents snacks if they asked for them. She indicated she did not offer snacks. During an interview on 05/01/12 at 4:45 p.m., CNA #7 indicated if the residents			

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	ask for snacks then she will give them a snack. She indicated they only give snacks if the residents ask for them. During an interview on 05/01/12 at 4:45 p.m., CNA #8 indicated she will ask the residents if they would like a snack. 3.1-21(e)			

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F0498 SS=G	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record review, the facility failed to ensure a CNA demonstrated competency and followed proper protocol while transferring a resident with a Hoyer lift, which resulted in a fracture requiring emergency room treatment, for 1 of 6 residents reviewed for proper use of a mechanical lift in a sample of 22. Resident # D Findings include: 1. The clinical record for Resident # D was reviewed on 5/3/12 at 10:30 A.M. This resident's diagnoses included, but were not limited to: distal tibia and fibula fracture, dementia, and aphasia. Resident # D's Significant change MDS (Minimum Data Set) assessment dated 8/30/11 indicated her cognition was severely impaired. She needed total assistance with 2 staff assistance with transfers and bathing. The MDS	F0498	1. Resident D was discharged from the facility prior to the survey. CNA # 12 was terminated from employment with the facility prior to the survey. Certified Nursing Assistant competencies for mechanical lift transfers were performed at the time of discovery of the improper transfer. 2. All residents using hoyer lifts have the potential to be affected. 3. Certified Nursing Assistants have been inserviced on use of mechanical lifts per Kindred policy and procedure and have performed return demonstration. Certified Nursing Assistants will use 2 trained staff for all mechanical lift transfers. Unit Managers will perform 5 random of observations per week of mechanical lift transfers on all shifts. 4. DNS will track and trend audit results. Results of these audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance. The facility respectfully requests an IDR for the severity of this citation. The event cited did not lead to the injury as cited as per facility	06/09/2012

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	indicated she required a mechanical lift with 2 staff assistance for transfers. The MDS indicated the resident did not have a history of falls. Review of Resident # D's care plan titled "...Assist with all ADL's (activities of daily living)..." dated 8/30/11, indicated, "...Hoyer lift for all transfers...." Review of a "Facility Incident Reporting Form" dated 9/20/11, indicated, "... (Resident # D) was observed by staff to be laying in bed. Her right lower leg appeared deformed....Interviews reveal (Resident # D) had been laid down for bed per Hoyer lift 20-30 minutes prior to discovery. CNA caring for (Resident # D) states she was unaware of injury. (Resident # D's) care plan listed Hoyer lift for transfers. No other staff observed anyone else in (Resident # D's) room in the interim between transfer to bed and discovery. Re-enactment of the transfer revealed that 1 CNA performed the transfer. (Resident # D) returned from ER with splinted right lower leg...." Review of a Radiology Report dated 9/20/11, indicated, "...Acute fracture of the distal tibia and fibula..." Review of a facility investigation/interview dated 9/20/11,		investigation of the event.	

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	indicated, "...(CNA # 12) took care of (Resident # D) today 9/20/11 from 6 A.M. - 2 P.M. States she transferred resident by herself c (with) Hoyer lift. She did not ask the nurses or (UM) (unit manager) myself for assistance. States resident did not hit legs on bed & showed no pain...." Review of an undated internal facility reenactment with CNA # 12, indicated, "...I did not have assistance with the transfer...." Review of a "Performance Improvement Form" dated 9/23/11, indicated, "...(CNA # 12)...Failure to follow procedure for Hoyer transfers: transfer of residents on 9/19/11 without assistance. This failure may have lead to injury of (Resident # D): fracture to tibia and fibula...." Review of CNA # 12's personnel file indicated she received training and education related to mechanical lifts on 1/28/11. Review of a facility policy titled "Mechanical Lift (Sling Lift)" revised 3/6/12, indicated, "...Obtain assistance from another staff member for transfer as necessary. Two people are required when using the Mechanical Lift..." This Federal tag relates to Complaint			

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	IN00107648. 3.1-14(i)			